

FILED APR 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7420

BIRTH NO. _____		REG. DIST. NO. <u>34</u>		PRIMARY REG. DIST. NO. <u>4045</u>		Registrar's No. <u>3</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Ashland</u>		c. LENGTH OF STAY (In this place) <u>1</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Ashland</u>		d. STREET ADDRESS (If rural, give location) <u>0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Addie</u> c. (Last) <u>Nichols</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 23 1949</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 10-1865</u>	
9. AGE (In years last birthday) <u>84</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Nathan Nichols</u>		13b. MOTHER'S MAIDEN NAME <u>Margaret Sapp</u>		14. NAME OF HUSBAND OR WIFE <u>Mahalia Nichols</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>10</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Frank Nichols Jefferson City, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis Chronic</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis</u> DUE TO (c) <u>✓</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u> <u>+22</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 1942, to <u>Mar 23, 1949</u> , that I last saw the deceased alive on <u>Mar 23, 1949</u> , and that death occurred at <u>7 4</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>J. C. Seeger, M.D.</u>				23b. ADDRESS <u>Columbia, Mo.</u>		23c. DATE SIGNED <u>3-29-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3-25-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Goshawk Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>Near Ashland Mo.</u>	
DATE REC'D BY LOCAL REG. <u>3-24-49</u>		REGISTRAR'S SIGNATURE <u>Mrs. Mildred Burnett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Burnett Ashland, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 91
Dated and Number
APR 13 1949
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

W. D. Burnett

Licensed Embalmer No. *3564*

P. O. Address *Ashtland Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.